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ABSTRACT

Although no specific personality disorder seems responsible for suicide behavior, it has been suggested that hysterical personality could predispose to suicide behavior. Schizoid, anti-social and obsessoid rigid personalities have been linked to high risk suicide attempts. This study elicited response patterns and attitudes of South African university students (N=283) to hypothetical stressful situations. Suicidal psychiatric patients (N=60) who had recovered from a current episode of mental illness served as controls. All subjects completed questionnaires consisting of seven attitude scales: (1) attitude to self; (2) attitude to life; (3) attitude to the world; (4) stress reaction; (5) happiness scale; (6) passive death wishes; and (7) active death wishes. The results revealed that 32% of the students and 56% of the patients would be inclined to suicide or the passive acceptance of death under stressful circumstances. Forty-eight percent of the students and 46% of the patients reported having attempted suicide. Twenty-two percent of the students and 30% of the patients thought future suicidal behavior was likely. Several target attitudes were identified as markers of possible future suicidal acts. Subjects identified as high-risk thought they had insufficient achievement in life, felt they should not have been born, considered themselves not understood or appreciated by their family, found death too far away, and had nervous reactions to stress with agitation and confusion. (ABL)

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PRONENESS TO SUICIDE : DOES IT EXIST ?

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INTRODUCTION

Several authors including Barraclough and Colleagues (1), Minkoff and Colleagues (2) Ovuga (3,4) and Weissman and Colleagues (5) have linked suicide behaviour to one or other aspect of personality functioning. Though no specific personality disorder seems responsible for suicide behaviour, it has been suggested that hysterical personality could predispose to suicide behaviour (6). Schizoid, anti-social and obsessoid rigid personalities have all been linked to high risk suicide attempts (7,8). It has even been suggested that suicide behaviour may be genetically determined (9).

The view expressed in this report is that certain members of the general population may be prone to suicide behaviour, and that suicide behaviour may be determined by the individual's inherent cognitive functioning. The paper reports the findings of a study designed to elicit the response patterns and attitudes of university students to hypothetical stressing situationsin Transkei.

SAMPLES AND METHODS OF STUDY

A total of 283 students at the University of Transkei completed a self-administered 32-question 139 response - item questionnaire consisting of seven attitude scales; namely : (1) Attitude to self (AS), (2) Attitude to life (AL), (3) Attitude to the World (AW), (4) Stress reaction (SR), (5) Happiness scale (HS), (6) Passive Death Wishes (PDW) and (7) Active Death Wishes (ADW). (Figure 1) Eighteen common symptoms of depression in Africans were included so as to relate student response patterns to the presence of probable psychopathology at the time the questionnaire was administered. Sixty successive suicidal psychiatric patients who had recovered from current episode of mental ill ness while in hospital served as controls. The questionnaire was administered to the patients by two trained nurses individually as most of the patients could not communicate in the English language. Of the 139 responses each of 99 significant responses was accorded a score of one if rated 'True" or zero if rated "False". The total score on each scale was computed using the T scores transformations. The entire questionnaire was based on the spontaneous remarks of other suicidal patients during previous psychotherapeutic sessions.

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Results

Prevalence of Suicide behaviour:

Thirty two percent of students and 56% of patients would be inclined to suicide or the passive acceptance of death under stressing situations. Forty eight per cent of students and 46% of patients had attempted suicide before. Twenty two per cent of students and 30% of patients thought a future suicide behaviour was likely. And 21.9% of students and 26.6% of patients experienced suicide behaviour amongst relatives or friends before.

Attitude profiles :

A constellation of response items indicated by at least 50% of "future suicidal" students or patients was used to define the psychological characteristics of 50 students (17.6%) and 18 patients (30%) who thought a future suicide act was likely for them. While considerable similarity was revealed in the response patterns of the two groups significant differences also emerged in some of the attitude scales.

Attitude to self (AS) : Both groups had overrall negative attitude to themselves. Students thought they were"not worth five cents" while patients believed they did "not achieve enough in life".

Attitude to life (AL) ;
No significant difference was noted. Sixty eight per cent of students and 77% of patients described the human condition as "difficult". Surprisingly neither groupsaw man's situation as "intolerable" or "hell on earth".

Attitude to the World (AW) :
Both groups thought the world offered less joy than they expected patients thought no-one understood or appreciated them and they wished they were not born.

Stress Reaction (SR) :
Difficult situations disrupt peace of mine, arouse feelings of insecurity, evoke a wish for death or suicide intentions or the miraculous end of hardships. Patients' reactions were more severe than those of students and were characterised by nervousness, agitation and confusion.

Happiness Scale (HS) :

There were no difference in students' and patients' conceptions of the sources of personal happiness. These sources included (1) Have one's needs met (2) Ability to solve one's problems successfully (3) Loving others or being loved by others (4) Being in the service of others. Students, but not patients, would wish to avoid changes in life at all costs.

Passive Death Wishes (PDW) :

The wish to die seemed to be accompanied in the two groups by internal debates about life, death and one's personal experiences. Patients felt natural death was too far to wait for. Students would wish to die twice if it was possible.

Active Death Wishes (ADW) :

Since choosing to kill oneself is a rare event, this analysis was based on an indication of at least one instance of an active desire by students or patients to kill themselves. Patients differed from students is not considering suicide act in response to business failure. One wonders if this was a reflection of patients' belief that they did not achieve enough in life.

Psycho-Social Correlates :

Table 1 sets out the mean T. Scores for students and patients on each of the seven attitude scales. Figure 2 based on this analysis shows that the response patterns of students are similar to those of suicidal patients. The lower mean T. Scores for group III suicidal patients than their student colleagues may have been due to the drug treatment they received in hospital.

Results suggest that high student T scores were correlated with the female sex and age below 25 years. (Table "). This finding confirms Ovuga's (10) earlier demonstration that significantly more individuals with serious death wishes were less than 35 years of age and that women tended to exhibit more anxiety during stress. Parental loss was significantly related only to patients' reaction to stress, happiness scale and passive death wishes.

Table 3 shows the levels of significance between likely future suicide behaviour or previous suicide attempt and the seven attitude profiles. For students, the possibility of a future suicide behaviour was related to personal conception of the sources of happiness, reaction

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to stress, attitude to oneself and attitude to the world. Among the patient population these variables did not relate significantly to the possibility of future suicide behaviour. Current active death wishes and stress reaction for patients did not relate significantly to previous suicide attempts. However for both population groups possible future suicide behaviour or previous suicide attempts were significantly related to the individual's current suicide intentions or death wishes.

In order to relate the expression of death wishes to current psychopathology, an assessment of the probable existence of depressive illness was carried out on the entire student population using a check-list of eighteen common symptoms of depression among black Africans. Six out of 18 symptoms indicated probable depressive disorder. Statistical analysis indicated very strong relationships between probable depressive illness and student's attitude to self, attitude to life, attitude to the world, reaction to stress and active and passive death wishes.

Discussion :

It was hoped that this study would help identify predictive characteristics of suicidal individuals in the general population, represented by students in this study. Immediate questions considered were (1) What personality attributes determine which suicidal individuals will go onto kill themselves in the future? (2) Should individuals considered suicide prone be urged to receive professional help? (3) Is suicidal behaviour learnt? (4) Does suicide proneness exist?

The answers to the first two questions can be determined only by the outcomes of future follow-up studies. The following target attitudes are, however, identified as markers of possible future acts:
(1) Insufficient achievement in life (2) Should not have been born (3) Nervous reaction to stress with agitation and confusion (4) Death is too far to wait for and (5) Not understood or appreciated enough by relatives.

The prevalence of suicidal feelings reported in this paper is probably too high. Paykel et al (11) reported a prevalence of death wishes of 2.3% in the past year while Schwab et al (12) reported a figure of 15.9%. In previous reports by Ovuga (3,4) the prevalence

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of death wishes in African patients ranged from 14% in Kenya to 30% in Transkei. Notwithstanding the varied prevalence figures and the underlying reasons for them, these figures seem to represent the probable size of the suicidal pool in the respective populations from which actual cases of potential suicides emerge. A simple technique to test the validity of the figures in this study was to have administer the questionnaire to the same respondents again, say after a period of six weeks. Though suicide behaviour is a dynamic phenomenon and minor differences might have been expected, the analysis of the two sets of data might have demonstrated the true state of affairs.

According to Bagley and Ramsay (13) suicide behaviour was significantly related to the individual's personal experience of suicide behaviour among relatives. In the present study no statistical relationship was established between these variables. The reasons for this may be found in the African!s social system. The black African is not yet individualised, remains answerable to group members and often acts only after consulting with others : The same reason might also explain, if only partially, the lack of statistical relationship between suicide intent in death wishes and marital status, religious affiliation, and level of educational achievement in the African patient (10).

It has been suggested that suicide behaviour may be learnt through conditioning and practice. It is also possible that negative social responses to suicide behaviour indeed promote this human response to stress. The personal experience and memory of a relative or friends' suicide might induce suicide behaviour in oneself under difficult situations in the future. And the role of heightened public awareness about the alleged virtues of suicide through public debate, education, advertisements and the activities of various Right of Way Societies seem to support the learning theories of suicide behaviour. However this view was not supported by the lack of statistical relationship between personal experience of suicide behaviour and student or patient T scores.

An attempt was made in this study to control the factor of psychopathology by using suicidal patients who had "recovered" from current episode of psychopathology. No psychotherapeutic interverntion was directed at the patients' suicidal feelings in order to avoid

influencing patients' response patterns. There was no reason to believe that students' level of psychopathology was serious enough to interfere with their functional abilities. It could be interpreted that student and patient levels of psychopathology were probably the same at the time the questionnaire was administered. Thirty eight per cent of students and 77% of patients indicated they had experienced symptoms of depressive disorder in the past three months. Yet the propotion of students' T. scores that ranged from moderate to high on each of the seven attitude scales was 86%. Paykel et al (11) described suicidal feelings as characterological phenomena and believed that these feelings ran a chronic course. More recently Ovuga (10) expressed the view that once death wishes made their first appearance they seemed to remain quiescent in people's lives (after receiving help) until they reappeared during stressful events. It is probable that latent proneness to suicide behaviour is independent of the presence of demonstrable psychopathology though student T scores were significantly related to the presence of current psychopathology. It appears probable that individual proneness to suicide behaviour may be inborn. It is hypothesized that the key issue in suicide behaviour and attitude to life, etc., involves the individual's personal responsibility and ability to successfully master the environment.

Problems in this respect may be the primary source of suicidal feelings. Stress and psychopathology appear to provide a background against which suicide behaviour is expressed. Viewed this way, death wishes and, ambivalance, a universal phenomenon in suicide behaviour, seem to function as positive motivational forces during stressful situation.

In General the results seem to suggest that more people than expected live under the threat of suicide at any time. The need to develop a rational means to identify at risk individuals in the general population appears obvious.

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Table 1. Mean T scores for suicide proneness scales for 283 students and 60 patients.

Scale	Groups of Patients			Groups of Students		
	I	II	III	I	II	III
.S	38.0	49.2	64.6	34.7	51.2	66.8
AL	00.0	49.9	62.7	00.0	49.3	65.5
AW	35.0	51.0	64.5	34.5	51.1	67.7
SR	35.3	50.0	64.1	36.0	46.9	69.2
HS	36.0	47.5	63.2	36.0	46.8	65.5
PDW	32.5	49.1	64.0	31.1	51.8	69.0
ADW	00.0	53.9	65.9	00.0	53.9	68.0

Key : Group I : 0 - 39
GroupII : 40 - 59
GroupIII : 60 +

Table 2. Relationship between attitude profiles and other variables for 283 university students.

Covariates	Significance Level	
All attitude scores - Parental loss	N.S.	
All attitude scores - Experience of Suicide Behaviour	N.S.	
AS - Mental Illness	0.0000	
AL - Mental Illness	0.0022	
AW - Mental Illness	0.0076	Predictive value
SR - Mental Illness	0.0000	AS (2)
PDW- Mental Illness	0.0000	AL (3)
ADW- Mental Illness	0.0003	SR (2)
AS - Age	0.0252	
AL - Age	0.0001	
SR - Age	0.0274	
PDW- Age	0.0000	
AL - Sex	0.0082	
PDW- Sex	0.0005	
AW - Sex	0.0354	

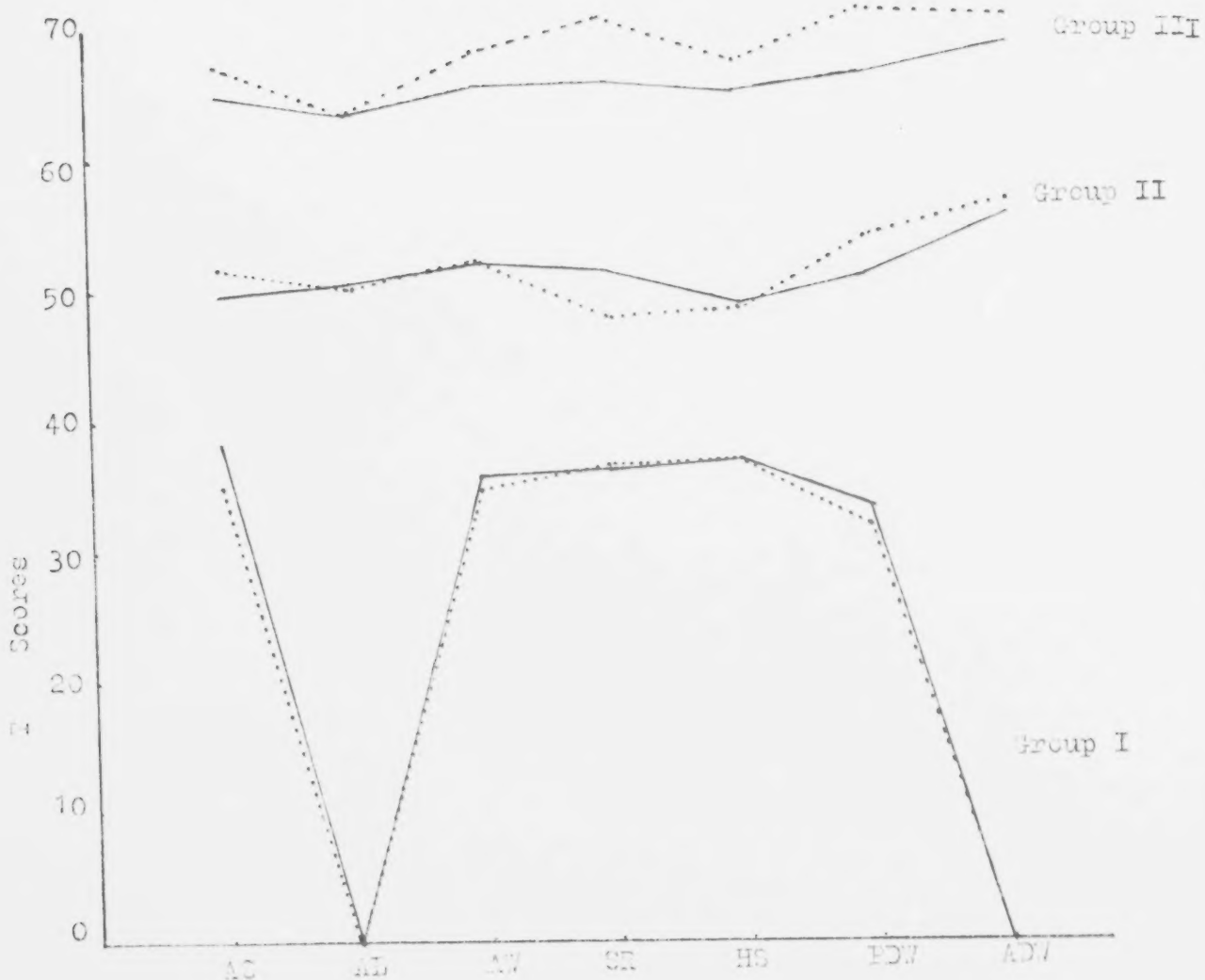
Table 3. Relationship between suicide behaviour and attitude profiles of 283 students and sixty suicidal patients.

Covariates	Significance Levels	
	Students	patients
AS : Future Attempt	0.0049	0.1678(N.S.).
AL : Future Attempt	0.0599 (N.S.)	0.0291
HS : Future Attempt	0.0000	0.3357(N.S.).
AW : Future Attempt	0.0031	0.9000(N.S.).
SR : Future Attempt	0.0014	0.0175
ADW : Future Attempt	0.0000	0.0001.
PDW : Future Attempt	0.0000	0.0003
SR : Previous Attempt	0.0233	0.5202 (N.S.)
ADW : Previous Attempt	0.0009	0.3154 (N.S.)
PDW : Previous Attempt	0.0005	0.0674 (N.S.)

Figure 1. Attitude Scales in Suicide Proneness Scale

AS	:	Attitude to Oneself
AL	:	Attitude to Life
AW	:	Attitude to the World
SR	:	Reaction to Stress
HS	:	Happiness Scale
PDW	:	Passive Death Wishes
ADW	:	Active Death Wishes

Figure 2 : Attitude profiles for 283 University Students and 60 suicidal psychiatric patients



Key : Students .....

Patients ——————